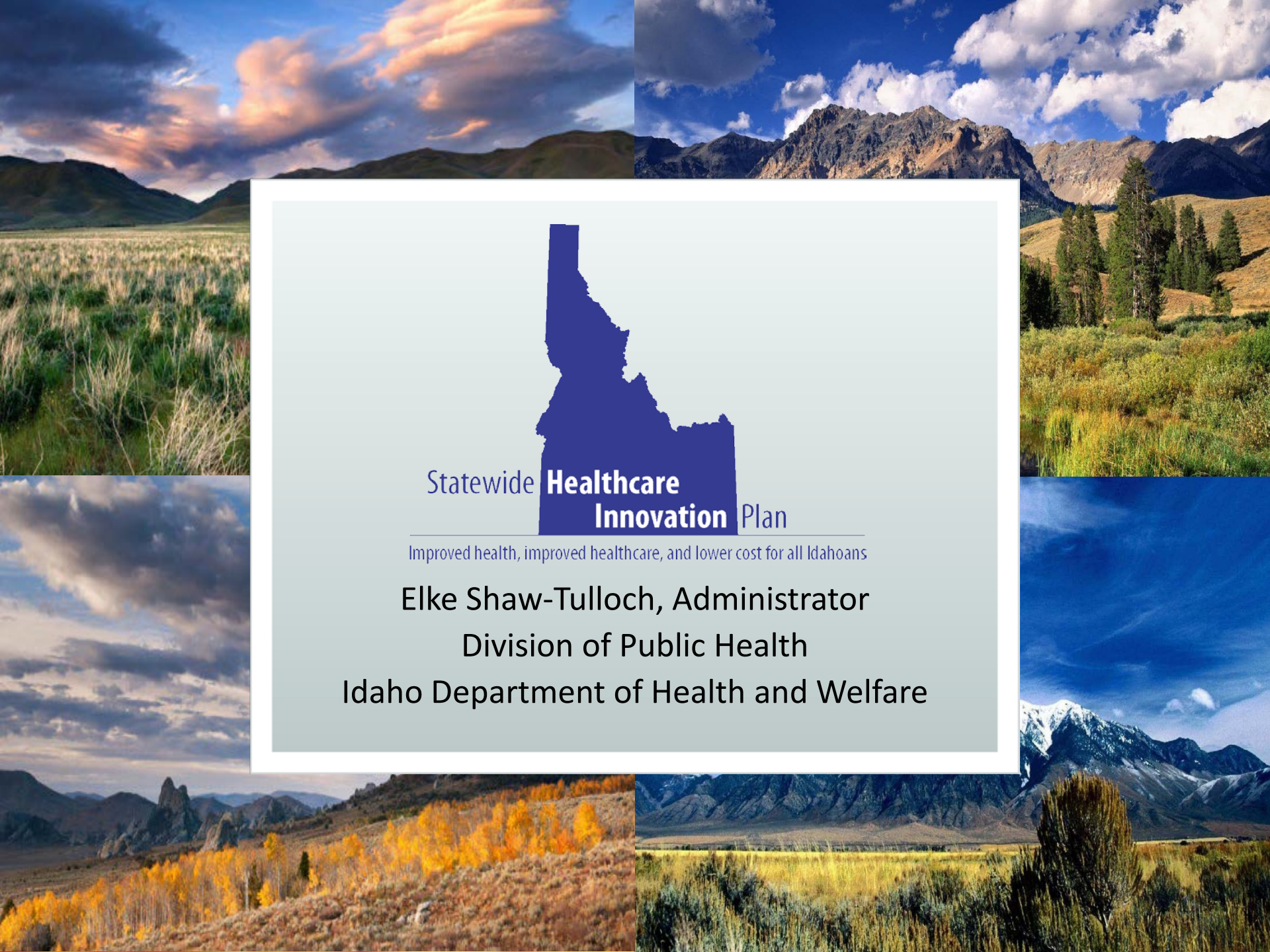
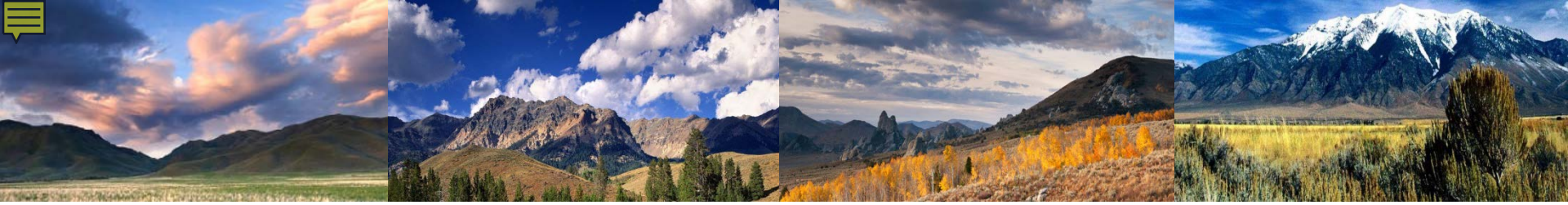


Statewide **Healthcare Innovation** Plan

Improved health, improved healthcare, and lower cost for all Idahoans

Elke Shaw-Tulloch, Administrator
Division of Public Health
Idaho Department of Health and Welfare



Idaho State Healthcare Innovation Plan
How did we get here?

- Idaho has been engaged in efforts to redesign our healthcare system for a number of years:
  - 2007 – Governor Otter convened Healthcare Summit
  - 2008 – Governor Otter tasked Select Committee on Health Care
  - 2008 – Idaho Health Data Exchange established
  - 2010 – Idaho Medical Home Collaborative established
  - 2013 –Idaho awarded CMMI planning grant to develop State Healthcare Innovation Plan (SHIP)
  - 2014 – Governor Otter establishes Idaho Healthcare Coalition (IHC)
  - 2014 – Idaho submits CMMI testing application to CMMI

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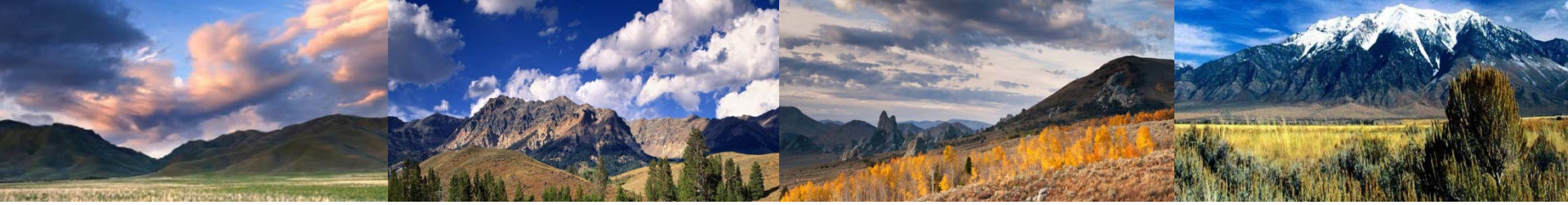

SHIP Model Test Grant Update

- Awards announced 12/16/2014. Idaho receives $39,683,813 award over 4 years.
- Model Test begins February 1,2015
- IHC will guide SHIP implementation and Model Test Grant
  - Work is supported by IHC Work Groups
- IDHW role:
  - Administrative support to IHC
  - Program implementation (hiring 8 positions)
  - Manage multiple contracts

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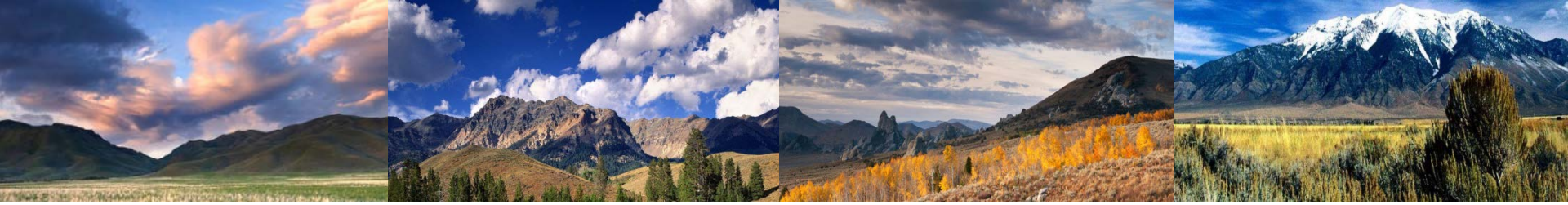

PRIMARY SHIP GOAL

Redesign Idaho's healthcare delivery system to evolve from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes.

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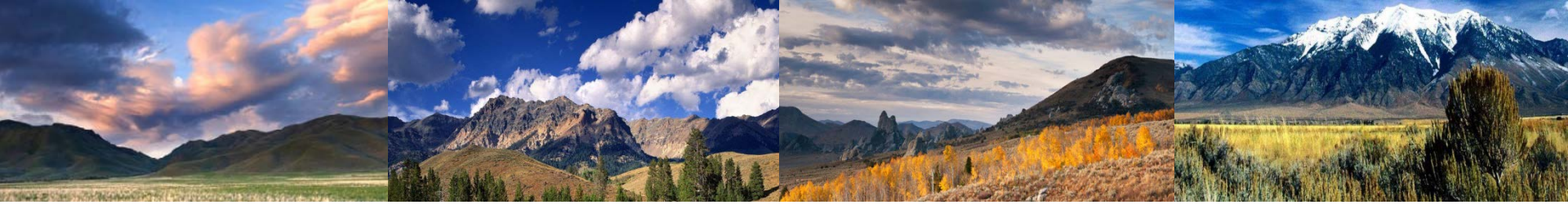

SHIP Supporting Goals

Goal 1: Transform primary care practices across the state into patient centered medical homes (PCMHs).

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.

Goal 3: Establish regional collaboratives to support the integration of each PCMH with the broader medical neighborhood.

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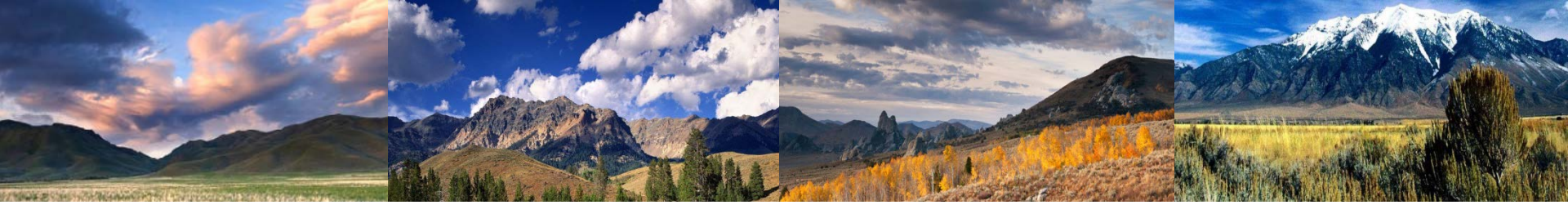

SHIP Supporting Goals

Goal 4: Improve rural patient access to PCMH by developing virtual PCMHs.

Goal 5: Build a statewide data analytics system.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

Goal 7: Reduce healthcare costs.

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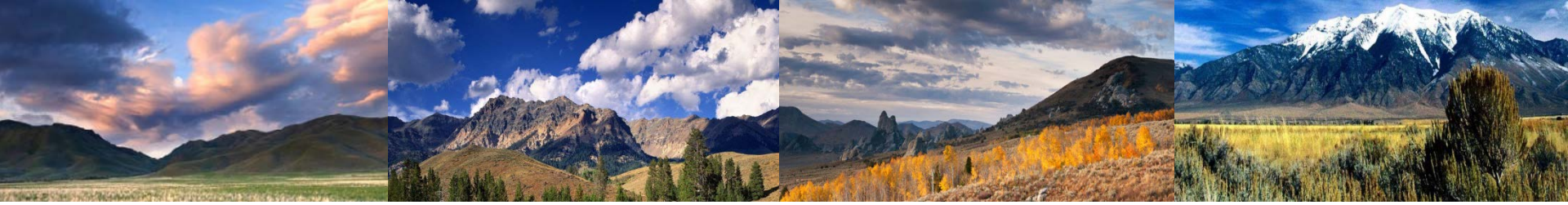

Oversees the development of this performance driven population management system

Idaho Healthcare Coalition

Support practices in transformation to a PCMH

RCs

Provides primary care services and coordinates care across the larger medical neighborhood of specialists, hospitals, behavioral health and long-term care services and supports

PCMH and Medical Neighborhood Care Team

CHEMS

Improved health by receiving all primary care services through a patient-centered approach

Patient

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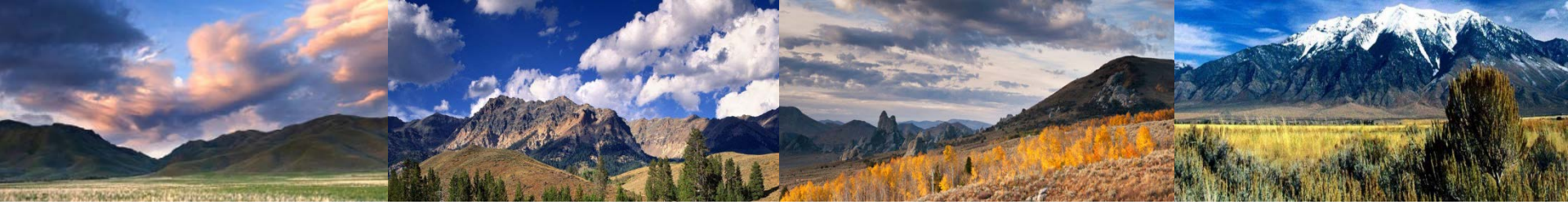

Model Design Key Elements

Idaho healthcare coalition

- Idaho Healthcare Coalition (IHC) charged with guiding the implementation of the SHIP.
- Coalition members includes providers, payers, policy makers and consumers.
- IHC supports and oversees coordinated system including:
  - Coordinates activities of the regional collaborative.
  - Convenes policy level discussions regarding system improvements.
  - Assures consistency and accountability for statewide metrics.
  - Collects and distributes quality and population health metrics.

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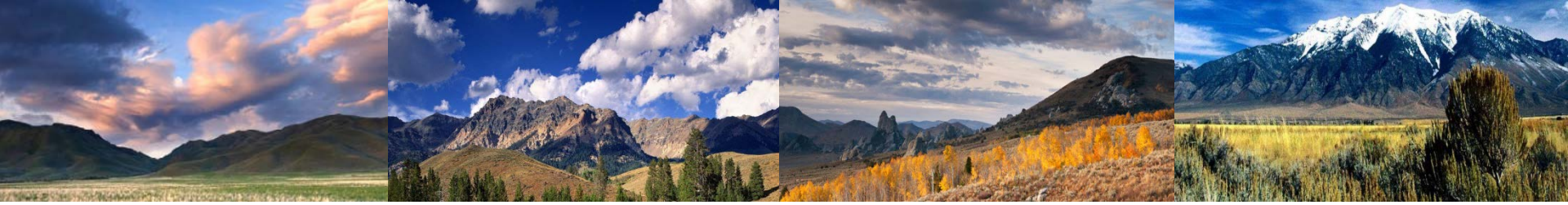

Model Design Key Elements

Patient Centered Medical Homes

- 55 primary care practices per year for 3 years to undertake practice transformation
- SIM request include funding for:
  - payment incentives for practices going through transformation
  - training, technical assistance and coaching for practice transformation
  - Participating PCMHs' EHR connection to Idaho Health Data Exchange
  - Technical assistance in clinic data collection and analytics

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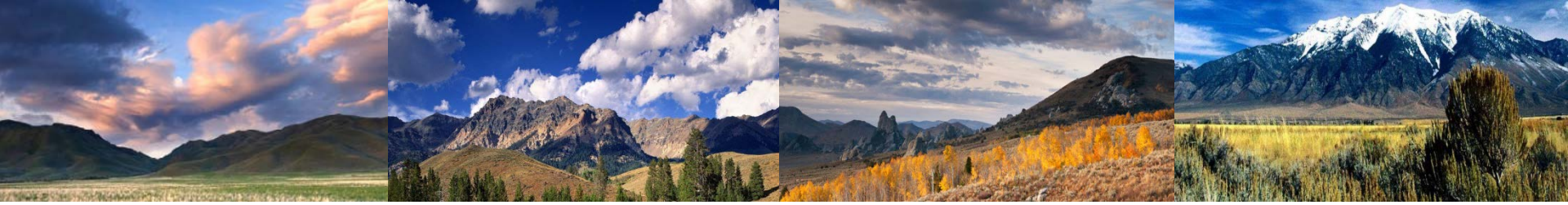

Model Design Key Elements

Quality Improvement

- Core quality measures identified for all PCMHs.
- All participating PCMHs will report on quality measures for all patients in their practice.
- In Year 1 three selected quality measures will be tracked statewide to establish a baseline.
  - Tobacco use.
  - Comprehensive diabetes care.
  - Weight assessment for kids.

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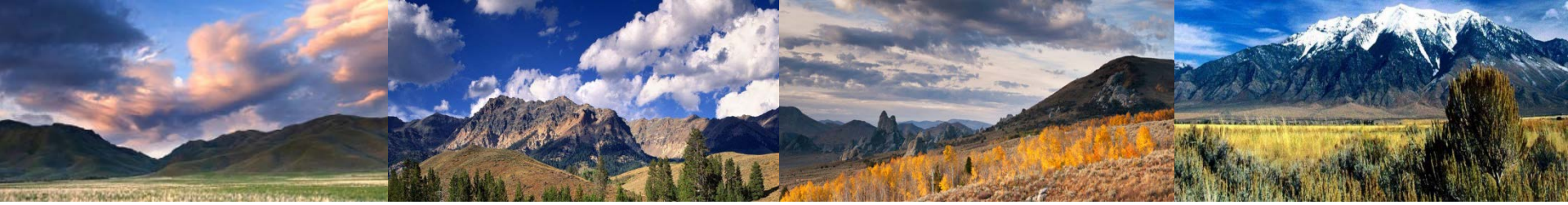

Model Design Key Elements

Virtual Patient Centered Medical Homes

- Designed to improve access to primary care in rural communities
- Focus on extending the PCMH model to rural communities through:
  - telehealth equipment and training
  - use of Community Health Workers and Community Health Emergency Medical Services

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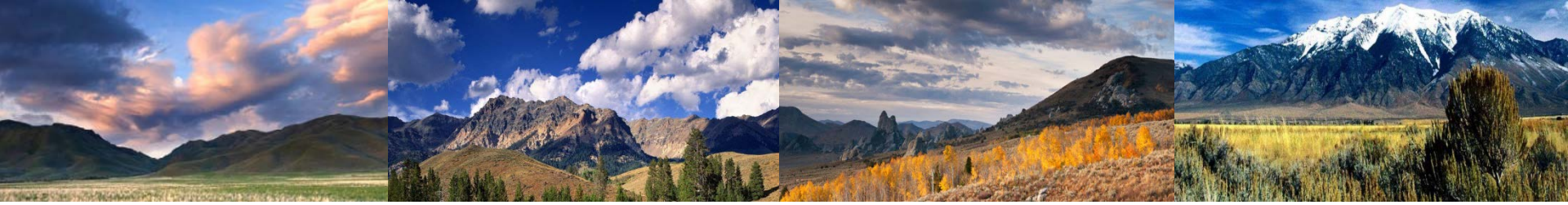
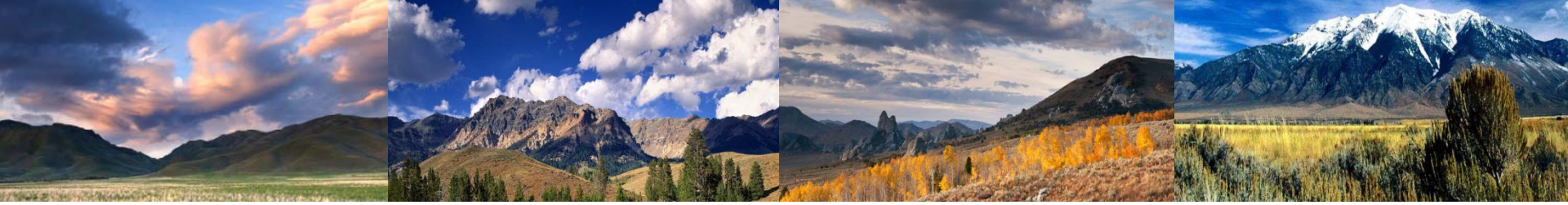


Model Design Key Elements

Data Sharing, Interconnectivity, Analytics and Reporting

- EHR capacity in healthcare providers' offices is critical.
- IHDE an important element to link patient information across providers/medical neighborhood.
- Expanded capabilities such as data marts, clinical analysis, and incorporation of claims data will be developed towards appropriate configuration to support PCMH data and reporting requirements, including use of interfacing technologies to leverage existing HIT systems.



Model Design Key Elements

Multi-payer Payment Model

- Payment model recognizes the value of the PCMH model.
- Payment escalates with increasing patient complexity and practice capabilities.
- Phased redesign strategy over five years:
  - Phase 1--establish per member/per month (PMPM) payments layered on current fee for service payment.
  - Phase 2—develop bonus payment based on use of evidence based practices and reporting adherence.
  - Phase 3—develop shared savings and/or value based payments for practices meeting cost/quality targets.
  - Phase 4-5—begin to expand complex payment models to include more complex patients.

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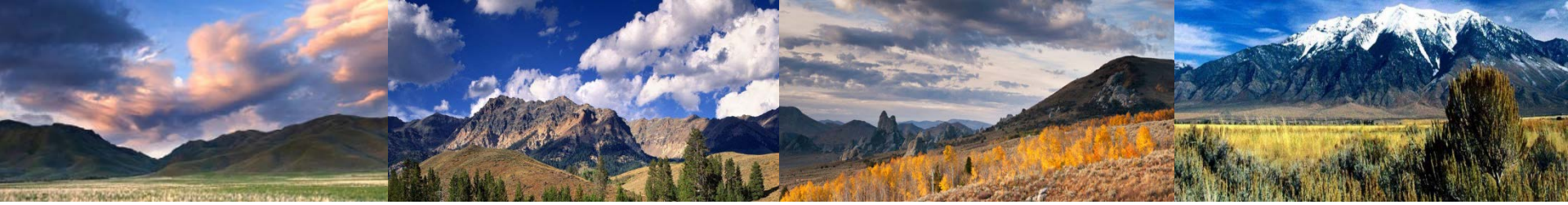

Model Design Key Elements

Regional Collaboratives

- Regional Collaboratives (RC) are part of the Idaho Healthcare Coalition addressing regional healthcare issues.
- RC performs advisory and administrative role creating support for PCMH and integration of 'medical neighborhood'.
  - Supports primary care practices in adoption of PCMH model with training, technical assistance, coaching.
  - Assists in integrating PCMH with other local health and community services.
  - Provides regional and practice-level data gathering and analytic support using protocols created at IHC.

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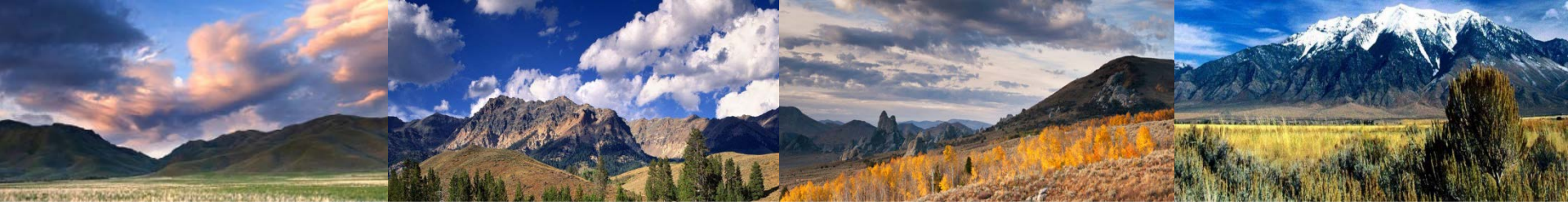

Next Steps

- IHC meeting monthly to oversee SHIP transformation.
  - Supported by Multi-Payor/Payment Reform, Behavioral Health/Primary Care Integration, Clinical/Quality Measures, HIT/Data Analytics and Population Health Work Groups
  - Collaborative with Idaho Medical Home Collaborative, Telehealth Council, CHEMS Task Force and others
- IDHW hiring staff and preparing contracts and requests for proposals.
  - Grant began February 1, 2015
  - Job postings are closing soon
  - Most contracts to begin July 1, 2015

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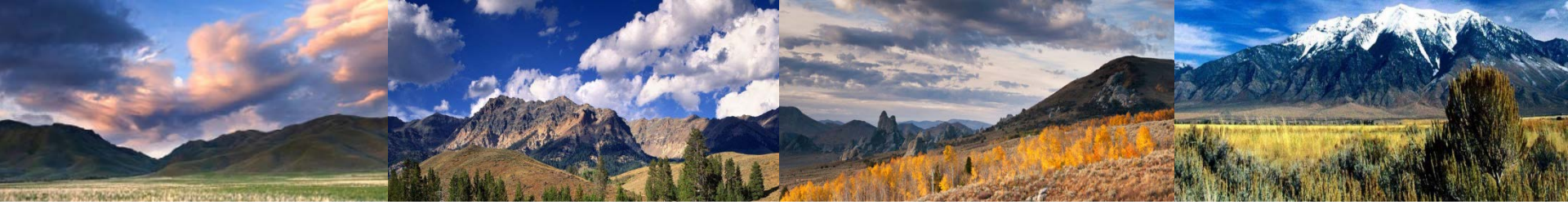

SHIP Opportunity:
Develop and implement a sustainable CHEMS program

- Project period 2/1/15-1/31/19
- Part of the "virtual" Patient Centered Medical Home (PCMH) to improve healthcare access and care coordination in rural areas.
- CHEMS is part of the primary care team.
- Virtual PCMH also includes the development of a Community Health Worker (CHW) program and expansion of telehealth.

Mary Sheridan, Bureau Chief
Bureau of Rural Health & Primary Care
Division of Public Health

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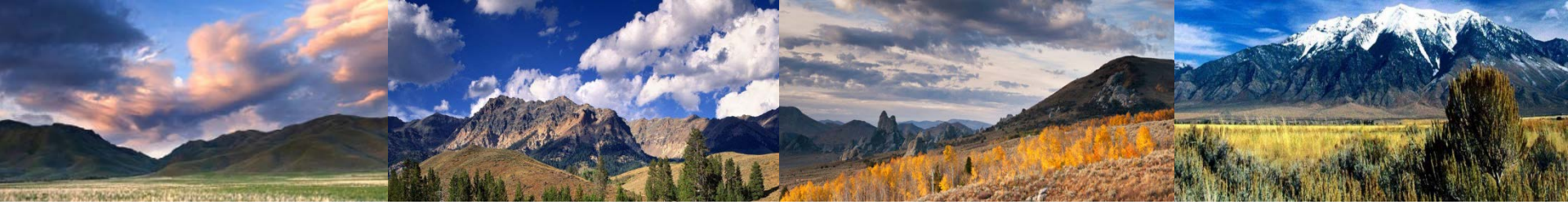

Aligned with the Triple Aim

1. Improve the health of populations
2. Improve patient experience of care (quality and satisfaction)
3. Reduce per capita healthcare costs

Testing CHEMS against the Triple Aim requires data collection, reporting, and evaluation.

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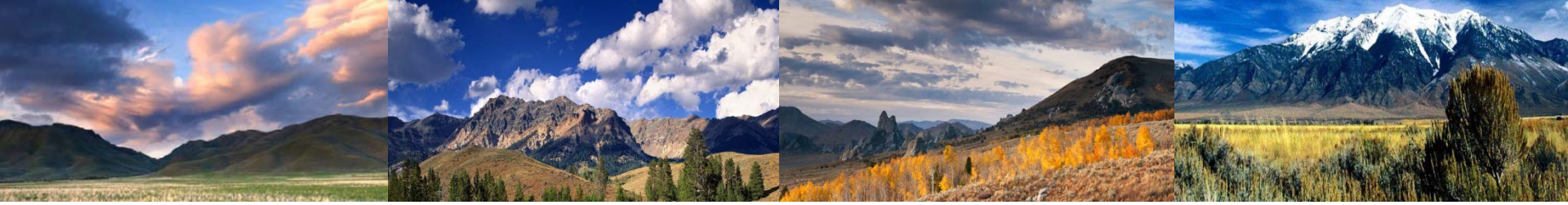

Funding Availability

- Community paramedicine course fees: 4 staff/3 agencies per year for 3 years (36 staff)
- Program development and course fees for BLS/ILS: 4 staff/3 agencies per year for 2 years (24 staff)
- Mentoring: support program development on-site and connecting program staff
- One time funding support of $2,500
- Continuing education conference in year-four
- Telehealth: connect from patient to PCMH

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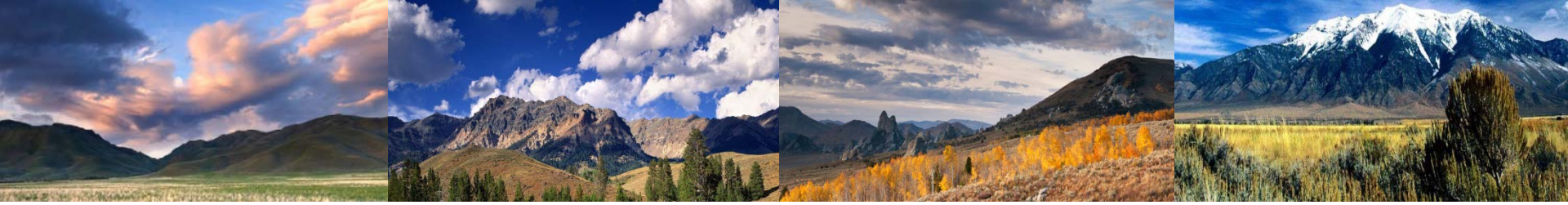

General Timeline
Year 1: February 2015-December 2015

- Program planning:
  - Tools and resources; “how-to” guide
  - Metrics and reporting
  - Sustainability
- Education
  - Paramedic program; develop BLS/ILS program
  - Mentoring
  - Medical director
- Outreach and recruitment
  - Build community awareness and identify 3 ALS agencies

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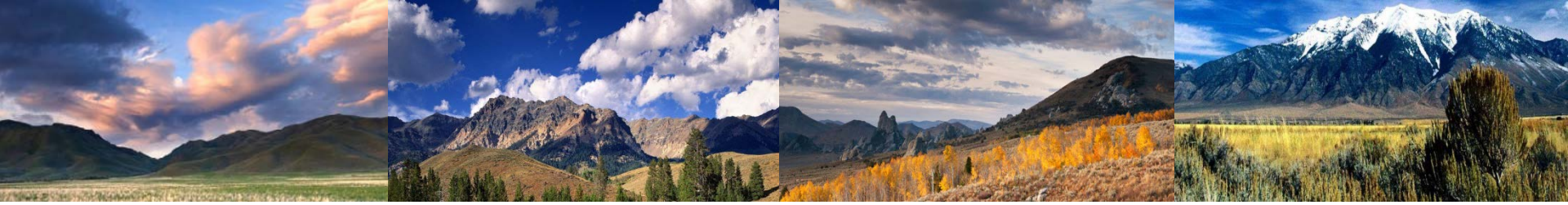

Year 2: January-December 2016

- First paramedic course; recruit 6 additional ALS agencies
- BLS/ILS education and delivery strategy defined; recruit 6 agencies
- Provide medical director education
- Clinical metrics and reporting method identified
- Telehealth expansion opportunities
- Refine sustainability plan
- Implement mentoring program

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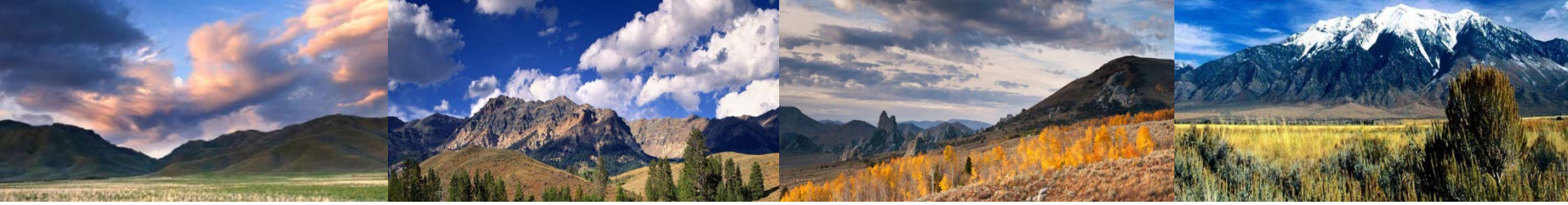

Year 3: January-December 2017

- Second paramedic cohort and confirm third
- First BLS/ILS cohort and confirm second
- Medical director education
- Data analysis and feedback
- Telehealth expansion opportunities

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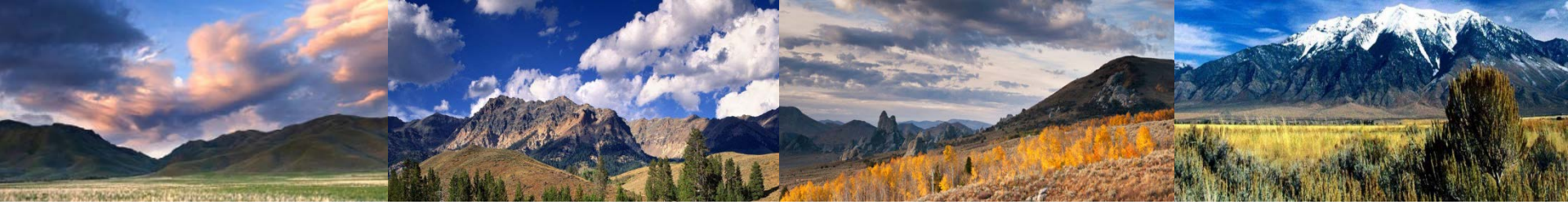

Year 4: January-December 2018

- Third paramedic cohort, second BLS/ILS cohort, and medical director education
- Evaluation: assess outcomes against Triple Aim
- Finalize sustainability plan
- Have a very big party

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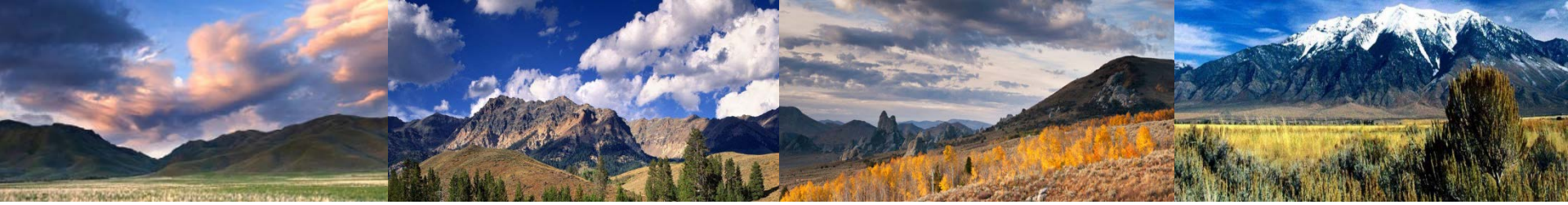

Year 1: Program Planning

- Collect best practice resources and policies for program implementation
- Identify required metrics and reporting process
- Identify or develop tools for conducting health needs assessments (with Regional Collaboratives)
- Begin developing a sustainability plan (integrate with Idaho Healthcare Coalition)
- Create an agreement for agencies participating in CHEMS initiative
- Develop “how-to” guide or coaching manual (BLS, ILS, ALS)
- Create telehealth expansion option with transportable exam station

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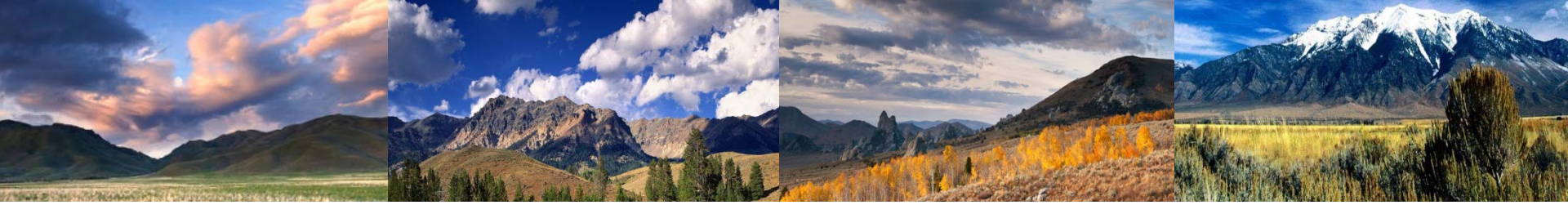

Year 1: Education

- Identify education program for paramedics (including process for tuition payments)
- Create program elements/scope for BLS and ILS agencies and educational delivery strategies
- Identify potential mentors and build mentoring program
- Determine medical director educational needs and implement strategy to address

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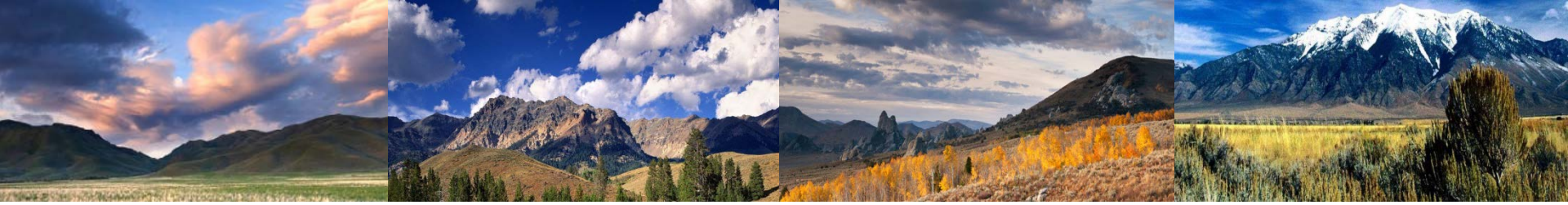

Year 1: Outreach and Recruitment

- Provide community education regarding CHEMS opportunity (agencies, primary care clinics, hospitals/critical access hospitals) and program details
- Identify potential year-one ALS agencies to facilitate the establishment of agreements for clinical sites
- Recruit 3 agencies (or more, depending on # of paramedics participating)

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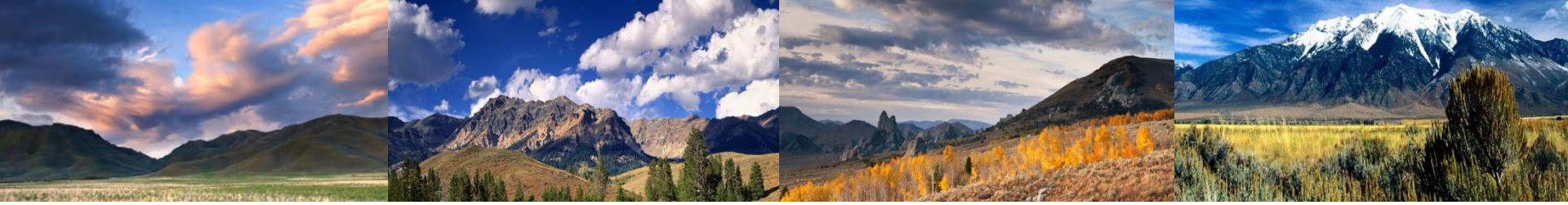

Questions